DENTIST LOAN REPAYMENT PROGRAM APPLICATION

ND Department of Health
Division of Health Facilities
SFN 53025 (8-2001)

Telephone: 701.328.2894

Dept. Use Only

File Number:

Name of Dentist				
Home Address	City	State	Zip Code	Home Phone
Office Address	City	State	Zip Code	Office Phone
Social Security Number	I prefer to be contacted at ☐ Home ☐ Office ☐ Either			

Identify your specialty

☐ General Dentistry ☐ Orthodontics ☐ Oral & Maxillofacial Surgery ☐ Prosthodontics

☐ Pediatric Dentistry ☐ Oral Pathology ☐ Periodontics ☐ Endodontics

☐ Other, please specify:

TRAINING

Dental School	Year of Graduation
Externship	Year of Completion
Residency	Year of Completion
Post Graduate	Year of Completion

Regional Board Exam Taken (Date) (specify region) National Board Exam Taken (Date)

Current Status

☐ Practice ☐ Teaching ☐ Administration
☐ Other

State Licenses	State	Year	License Number

Practice Experience	State	Type	Years
Hospital Privileges	State	Type	Years

OUTSTANDING DENTAL EDUCATION LOANS

Lender/Address	Loan #	Amount	Balance	Date Loan Must Be Paid

Are you in default on any loans? If yes, identify loan and amount.

How much money are you requesting? (You may request no more than $80,000)

Name of North Dakota community where you will practice	Date you will be able to begin

Have you had a dental license in any state or country other than North Dakota?
If yes, please specify.

Are you currently in litigation? If yes, please explain.

EMPLOYMENT HISTORY (List most recent employer first)

Employer	Address	Dates Employed

I will accept Medicaid assignment in proportion to the percentage of Medicaid clients in my practice area.
Yes ☐ No ☐

1. Attach three letters of recommendation.
2. Attach a copy of your North Dakota dental license.
3. Attach letters of support from the community you would like to serve.

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a dental loan repayment subject to the provisions of North Dakota Century Code Chapter 43-28.1 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health.

_____ _____
Signature Date

State of _____)
) ss
County of _____)

On this _____ day of _____, year _____, before me personally appeared _____ who having been sworn states that to the best of his/her knowledge and belief the statements in the foregoing application are true.

_____
Notary Public

(Seal)

My commission expires _____

Return the completed application to:

Gary Garland, Director
Office of Community Assistance
Division of Health Facilities
ND Department of Health
600 East Boulevard Avenue, Dept. 301
Bismarck, ND 58505-0200